

Guidance: Creating a Framework for Administering Behavioral Health Screenings

Select screening tools:

1. Identify a validated* screening tool for the population and behavior risk
2. Determine screening frequency based on each tool's guidance and recommendations.

Prepare your agency:

1. Create a universal screening policy for the population. The policy should include a response protocol for positive screens and crisis intervention.
2. Staff should receive training on the screening tool and the policy. Staff should administer the screens consistently during all applicable interactions.
3. Ensure all staff are equipped and trained to explain to clients the purpose of the screening tool, with whom the information will be shared, and who will review and follow-up with the patient regarding their responses and when.
4. Integrate universal screening into office workflow. Determine roles and responsibilities (e.g., who will ask the patient to complete the screen, discuss results with the patient, provide relevant education and resources, coordinate treatment when indicated).

Establish and formalize a local system of care:

1. Ensure the local system of care meets the behavioral health needs of clients and their families. The referral network should consist of a wide range of clinician types and treatment services.
2. Execute Memorandum of Agreements/Understanding (MOA/MOU) with behavioral health clinicians and/or centers for treatment referrals and improving timely access to mental health care.
3. Follow-up with patients and referral partners to ensure the connection was successfully completed.

Capture the data:

1. Enter all screens and action plans into DAISEY, or other electronic health record systems, when applicable.

Support Resources:

In addition to the following guidance, the following resources are available to local programs to support the identification, intervention, referral, and treatment of clients with behavioral health concerns:

Perinatal Behavioral Health

- Perinatal Mental Health Integration [Toolkit](#)
- Perinatal Substance Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) [Toolkit](#)
- Kansas Connecting Communities (KCC) offers free provider-to-provider psychiatric consultation and care coordination support, access to free trainings, and best practice recommendations, including resources and referral support. For more information, call the Consultation Line at 833-765-2004 or visit the [KCC webpage](#).

Pediatric Behavioral Health

- Pediatric Mental Health Toolkit: *Coming soon!*
- Pediatric Substance Use Screening, Brief Intervention, and Referral to Treatment (SBIRT) Toolkit: *Coming soon!*
- KSKidsMAP supports primary care physicians and clinicians' treatment of children and adolescents with behavioral health concerns through a Consultation Line, mental health and community resources, toolkits and best practices information, and KSKidsMAP TeleECHO Clinic. For more information, call the Consultation Line at 1-800-332-6262 or visit the [KSKidsMAP webpage](#).

*A validated screening tool is an instrument that have been tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition).¹

¹ The Joint Commission. *Definition of validated and non-validated screening tool for substance use*. Retrieved on 5/10/21 from [here](#).

Patient Health Questionnaire (PHQ-9)

Depression Screening	
Risk Assessment	Assessment and monitoring for depression severity.
Administration	<ul style="list-style-type: none">• 9-item questionnaire + 1 patient-rated item• Self-Administered• Takes less than 5 minutes to complete
Ages	11+ Note: While the PHQ-9 is validated for use with patients ages 11 and older, the PHQ screener developers also created a PHQ for adolescents (PHQ-A). The PHQ-A is the preferred screening tool for measuring risk of depression in patients ages 11-17.
Frequency	<ul style="list-style-type: none">• Annually• ACOG recommends screening pregnant/postpartum women for depression and anxiety at least once during the perinatal period. If screened during pregnancy, an additional screening should occur during the postpartum visit.<ul style="list-style-type: none">▪ Note: The EPDS is a comprehensive screen for measuring risk of depression and anxiety. If not using the EPDS, the GAD-7 should be used along with the PHQ-9 for perinatal patients.• Kansas Medicaid policy supports Postpartum Support International’s recommendations: Up to 3 times during the prenatal period, and up to 5 times during the 12-months postpartum period
Pre-Screening Tool	PHQ-2
References	<ul style="list-style-type: none">• PHQ Instruction Manual• KDHE: Perinatal Mental Health Integration Toolkit• Kansas Medicaid: Maternal Depression Screening Policy Guidance• PHQ-9 Language Translations
Rationale	Follow the U.S. Preventive Services Task Force recommendation to screen for depression in the general adult population, including pregnant and postpartum women.

Introduce screening tool and establish rapport.

Introduce the screening tool to the patient; a sample script is included, below. Scripts can be customized for clinic use. If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of unidentified depression.

Sample Script: I would like to ask you a few questions about how you have felt over the past 2 weeks. As we take your blood pressure and temperature we also want to assess your mental well-being because it can impact your overall health. Please answer these questions, thinking about how you have been feeling over the past 2 weeks.

Administer the PHQ-9 screening.

Patient responds to questions 1-10 based on how they have felt in the past 2 weeks.

The final question, #10, asks the patient to report ‘how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? This single patient-rated difficulty item is not used in calculating any PHQ score but rather represents the patient’s global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

Scoring the screen and determining risk level.

Assign scores of 0, 1, 2, and 3 to the response categories of ‘not at all,’ ‘several days,’ ‘more than half the days,’ and ‘nearly every day,’ respectively. The total PHQ-9 score for the 9-items ranges from 0 to 27.

MINIMAL/MILD Risk <i>Score 0 - 9</i>	MODERATE Risk <i>Score 10-14</i>	MODERATELY SEVERE Risk <i>Score 15-19</i>	SEVERE Risk <i>Score 20+</i>
<p>At low risk of experiencing depression. Provide positive reinforcement</p>	<p>Indicates further discussion is needed to determine the most appropriate intervention. A treatment plan should be started with the consideration of including counseling, follow-up and/or pharmacotherapy. If needed, make referral for diagnostic assessment and treatment by a primary care provider and/or mental health specialist.</p>	<p>Provide brief intervention and referral for diagnostic assessment and treatment (pharmacotherapy and/or psychotherapy) by a primary care provider and/or mental health specialist. Follow up with patient to make sure they accessed and received care.</p>	<p>Indicates immediate treatment is needed. There should be an immediate initiation of pharmacotherapy** and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy, collaborative management, and/or emergent services as indicated.</p>

* It is important to note the need to complete a diagnostic assessment prior to initiating pharmacotherapy. Diagnostic algorithms for the PHQ are included in the PHQ Provider Manual.